

## MISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-017824

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

4792

STATE FILE NUMBER

FILED MAY 9 1963

## 1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)

OR  
TOWN

St. Louis

Length of stay in 1b

## 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Missouri b. COUNTY

c. CITY

OR  
TOWN

St. Louis

Inside Limits

Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital, give location)

HOSPITAL OR  
INSTITUTION

Homer G. Phillips

Inside Limits

Yes ☒ No ☐

d. STREET (If outside, give location)

ADDRESS

4257 W. Easton

Reside on Farm

Yes ☐ No ☒3. NAME OF DECEASED  
(Type or print)

First

Middle

Last

Cornelius

King

4. DATE

Month

Day

Year

OF  
DEATH

4

30

63

## 5. SEX

Male

## 6. COLOR OR RACE

Negro

7. Married ☒Widowed ☐

## 8. DATE OF BIRTH

Never Married ☐ Divorced ☐

## 9. AGE (last birthday)

5-17-1910

## 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

LABOR

## 11. BIRTHPLACE (City and state or country)

Memphis Tenn

## 12. CITIZEN OF WHAT COUNTRY

U.S.A

## 13a. FATHER'S NAME

JESSIE KING

## 13b. MOTHER'S MAIDEN NAME

UNKNOWN

## 14. NAME OF HUSBAND OR WIFE

Heloise King

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give year or dates of)

NO NO

## 16. SOCIAL SECURITY NO.

00

## 17. INFORMANT

Heloise King

## Address

5643 Julian

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

## PART I. DEATH WAS CAUSED BY:

## IMMEDIATE CAUSE (a)

Cerebral Hemorrhage

INTERVAL BETWEEN  
ONSET AND DEATH

Undet.

## DUE TO (b)

Arteriosclerosis

## DUE TO (c)

331x

## PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

## PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown

## 19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒

## 20a. ACCIDENT

☐

## SUICIDE

☐

## HOMICIDE

☐

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

## 20c. TIME OF INJURY

Hour

Month, Day, Year

a.m.

p.m.

20d. INJURY OCCURRED WHILE AT WORK ☐NOT WHILE AT WORK ☐

## 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

## 20f. CITY, TOWN, OR LOCATION

## COUNTY

## STATE

## 21. I attended the deceased from

4-28-63

to 4-30-63

and last saw him alive on 4-30-63

## Death occurred at

11:05 P.

m on the date stated above, and to the best of my knowledge, from the causes stated.

## 22a. SIGNATURE

(Degree or title)

## 22b. ADDRESS

2601 N. Whittier

## 22c. DATE SIGNED

5-1-63

## 23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

## 23b. DATE

5-6-63

## 23c. NAME OF CEMETERY OR CREMATORY

Washington Park

## 23d. LOCATION (City, town, or county)

Berklee

## (State)

MO

## 24. FUNERAL DIRECTOR

Price E. Ltd. Co

## ADDRESS

2829 Washington

## 25. DATE RECD. BY LOCAL REG.

MAY 2 1963

## 26. REGISTRAR'S SIGNATURE

Paul Smith, M.D.

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

INSTEAD OF

DATE AMENDED

DOCUMENT

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Edward A. Flynn*

Licensed Embalmer No. 4444

P. O. Address 4202 Trinity Ave

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.